WELLNESS PERSPECTIVES PART 1: HISTORY, PHILOSOPHY AND EMERGING TRENDS

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Abstract
The health promotion/wellness movement is a relatively recent phenomenon. Health professionals continue to struggle with definitions of these constructs, implementation protocol, and evaluative strategies. As a means to address these issues, Wellness Perspectives: Research, Theory and Practice offers a three-part series. Part I will discuss the brief history of the health promotion and wellness field including some philosophical tenets and emerging trends. Part 2 of the series will outline a protocol to plan and to implement effective health promotion/wellness programs. Part 3 will discuss some current issues related to the evaluation of health promotion/wellness programs and discuss guidelines for effective evaluation.

Article:
When contrasted with other political and social issues, (e.g., civil liberties, women's rights, workers' rights, etc.) the health promotion/wellness movement is a relatively recent phenomenon. As such, there tends to be a lack of direction and clear purpose for health promotion and wellness. In this manuscript, the authors discuss some of the historical events that have shaped the health promotion movement and highlight some emerging trends.

DEFINING HEALTH PROMOTION/WELLNESS
The terms, health promotion, wellness and health enhancement, have been used synonymously for several years. Although some of these terms frequently take on fad connotations, it is important to examine them to lay a foundation for future discussions.

It is important to differentiate between medical care, disease prevention, and health promotion. All too often, medical care and disease prevention programs are mistaken for health promotion.

Medical care refers to traditional medical intervention as we know it in the United States. It begins with the sick and seeks to help keep them alive, make them well, or minimize their disability.

Disease prevention begins with a threat to health—a disease or environmental hazard—and seeks to protect as many people as possible from the harmful consequences of that threat. Boiling drinking water after a flood or rabies control efforts are common examples of disease prevention.

In contrast, health promotion begins with people who are basically healthy and seeks the development of community and individual measures which can help them to develop lifestyles that can maintain and enhance their state of well-being.

Definitions of health promotion have traditionally included more than just educational interventions. For example, Leavell and Clark (1965) defined health promotion as

> any intervention directed to maintain the health status of individuals and groups. This implies that the promotion of health includes healthy and secure work conditions, education, adequate housing, nutrition, recreation, etc., and not be disease-specific. (p.14)

The American Public Health Association (1987), in its background paper establishing criteria for the health promotion programs, states that health promotion

> [denotes a wide variety of individual and community efforts to encourage or support health behavior and environmental improvement where these goals and objectives have been previously determined, usually on the basis of epidemiological data, to be important. (p. 89)

O'Donnell (1986) defines health promotion as “the science and art of helping people change their lifestyles to move toward a state of optimal health” (p. 4). Green (1986) defines health promotion as "any combination of health education and related organizational, economic, and environmental supports for behavior conducive to well-being" (p.17). Again, it should be emphasized that, by definition, health promotion embraces a variety of intervention strategies (economic, social support, social policy, etc.) designed to elicit desired health-related behaviors or to establish healthy environments. Yet, health promotion, in recent years, has been equated almost exclusively with a focus on personal responsibility for health and health status. Wikler (1987) states, "Health promotion is frequently said to proceed from the premise that individuals are responsible for health" (p. 11). These concepts of health promotion support the notion that health is primarily the responsibility of the individual. What is the basis for this notion?

THE RELATIONSHIP BETWEEN BEHAVIORAL RISK FACTORS AND HEALTH

The relationship between behavior and the health status of Americans has been examined extensively. Increased public awareness of the relationship between lifestyle and health has fostered a conceptual change regarding how we view health. Kiefhaber and Goldbeck (1984) state that this conceptual shift is reflected in a Louis Harris survey which found that 92.5% of those adults surveyed agreed with the statement, "If Americans lived healthier lives, ate more nutritious food, smoked less, and maintained proper weight and exercised regularly, it would do more to improve our health than anything doctors and medicines could do for us." The implication of this conceptual shift is the explicit increased emphasis on the individual's role in the maintenance of health and the genesis of illness.

Changes in the leading causes of morbidity and mortality clearly show a shift from infection-borne diseases to chronic degenerative diseases. These diseases are influenced by lifestyle. Table 1 (National Center for Health Statistics, 1983) shows these changes in the primary causes of death in the United States.

The information in Table 1 indicates that lifestyle is a more important determinant of health status today than it was in 1900. For example, in 1900 the leading causes of death were predominantly communicable diseases. These communicable diseases can affect anyone at any stage across the lifespan regardless of his or her lifestyle. Through improved nutritional and sanitary practices and the development and widespread use of antibiotics and vaccines, these diseases have been effectively controlled in the United States. Conversely, the leading causes of death in the United States today are chronic conditions which, to a large extent, are functions of personal health lifestyles. The Centers for Disease Control (Iverson, 1984) estimate that health lifestyle factors contribute to 54% of all deaths due to heart disease. Lifestyle risk factors for heart disease include smoking, hypertension, lack of exercise, obesity, and stress. Table 2 highlights some of the major risk factors contributing to the 10 leading causes of death in the United States today.

Again, it is important to note that most of the risk factors which are contributing to the leading causes of death are either behaviors or the results of behaviors. However, these behaviors occur in and are influenced by the environment.

Table 1

Changes in the Primary Causes of Death (1900-1980)

1900	1940	1980
Pneumonia/Influenza	Heart Disease	Heart Disease
Tuberculosis	Cancer	Cancer
Diarrhea/Enteritis	Stroke	Stroke
Heart Disease	Nephritis	Accidents*
Stroke	Pneumonia/Influenza	Respiratory Diseases
Nephritis	Accidents[b]	Pneumonia/Influenza
Accidents[a]	Tuberculosis	Diabetes
Cancer	Diabetes	Cirrhosis
Senility	Accidents[c]	Arteriosclerosis
Diphtheria	Premature Birth	Suicide

[a] all types of accidents
[b] excluding automobile accidents
[c] motor vehicle accidents only

Table 2

Risk Factors and Cause of Death

Major Causes of Death	% of All Deaths	Risk Factors
Heart Disease	37.8	smoking* hypertension* elevated serum cholesterol* diabetes stress family history
Malignant Neoplasms	20.4	smoking* worksite carcinogens* alcohol diet* environmental carcinogens
Stroke	9.6	hypertension* smoking* elevated serum cholesterol* stress
Accidents (other than motor vehicles)	2.8	alcohol* drug abuse smoking (fires) product design handgun availability
Influenza and Pneumonia	2.7	smoking vaccination status*
Motor Vehicle Accidents	2.6	alcohol* no seat belts*

		speed* roadway design vehicle engineering
Diabetes	1.7	obesity*
Cirrhosis of Liver	1.6	alcohol abuse*
Arteriosclerosis	1.5	elevated serum cholesterol*
Suicide	1.5	stress* alcohol and drug abuse gun availability

* Major risk factors

The Centers for Disease Control (CDC) realize the important contribution that lifestyle and environment make in all causes of death. To this end, the CDC have predicted the relative impact of lifestyle, environment, the health care delivery system, and heredity on the major causes of death (Iverson, 1984). Table 3 highlights the impact of these four variables on the 10 leading causes of death.

Table 3
Influence of Lifestyle on Death Causation

Cause of Death	Lifestyle	Environment	HCD	Heredity
Heart Disease	54%	9%	12%	25%
Cancer	37%	24%	10%	29%
Stroke	50%	22%	7%	21%
Accidents[a]	69%	18%	12%	1%
Accidents[b]	51%	31%	14%	4%
Influenza/Pneumonia	23%	20%	18%	39%
Diabetes	34%	0%	16%	50%
Cirrhosis	70%	9%	3%	18%
Suicide	60%	35%	3%	2%
Homicide	63%	35%	0%	2%

[a] motor vehicle accidents
[b] all other accidents

It is important to note that although health experts may disagree on the exactness of these percentages, there is consensus regarding the relative impact of each factor and the overall contribution of lifestyle (Iverson, 1984). It is interesting to note again that many of the determinants of health and illness are a function of lifestyle or environment, conditions which may be modifiable. The report, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (U.S. HEW, 1979) summarized the causes of the major killers in these words:

We are killing ourselves by our careless habits.

We are killing ourselves by carelessly polluting the environment.

We are killing ourselves by permitting harmful social conditions to persist--conditions like poverty, hunger, and ignorance—which destroy health, especially for infants and children. (p. 8)

Again, the emphasis here is on individual and collective responsibility for health. Solving some conditions (e.g., environmental pollution, poverty) necessitates working together; however, there are numerous health problems (e.g., smoking, lack of exercise, stress, etc.) which can be solved by changes in individuals' behaviors and supportive environmental changes. In essence, the greatest promise for improving the health status of the citizens of the United States rests with health promotion and disease prevention. At this juncture, it is important to address some of the ethical concerns related to an emphasis on personal lifestyle factors inherent in some of our health promotion endeavors.

VICTIM BLAMING

Minkler (1989) believes that the concept of health promotion has emerged for reasons such as control of health care costs, limitations inherent in the medical care system as it currently exists, and a political climate supportive of individual responsibility for health rather than governmental or societal responsibility. Warner (1987) states that "Health promotion is frequently said to proceed from the premise that individuals are responsible for their health" (p. 11). It is important to explore the rationale and limitations of this premise.

Kaplan (1984) believes that many health promotion practitioners make assumptions about the cause and effect relationship between behavior and health. These assumptions are

- that specific behaviors create risk for serious illness,
- that changes in risk factors cause changes in health status,
- that behavior can be easily changed, and
- that behavior programs are cost effective. (p. 757)

Further, Kaplan believes that these assumptions are not universally supported by research data. Yet, adherence to them by health professionals often yields an individual-oriented approach to health promotion.

Many health conditions are more effectively addressed through avenues other than changing personal lifestyle. For example, most worksite stress management programs focus on training the employee to relax, meditate, better manage time, or engage in biofeedback techniques to reduce his or her stress response. Yet, a more effective way to reduce levels of stress within a corporation might be to eliminate or ameliorate those institutional and interpersonal factors within the corporations which cause stress (such as poor communication channels, rigid schedules, etc.). Such an approach would imply a share of responsibility for work-related stress between employees and the employer.

Kilwein (1989) provides an emotional argument to highlight the victim-blaming nature of the health promotion movement. He states, "What started out as a very noble enterprise has, in some cases, deteriorated into an intolerant, highly self-righteous and punitive campaign" (p. 9).

The victim-blaming nature of the health promotion movement allows us to be rude to smokers and discriminate against the obese. Clearly, such is not the intent and the health promotion movement should not provide a justification to blame the individual for health problems, cause guilt, or heap indignity on our fellow man.

The emphasis on individual responsibility for health has lead to a decline in health benefits and a reduction of social and governmental programs to improve health (McLeroy, Gottlieb, & Burdine,1987). Placing the blame on the individual makes it easier to ignore the impact of other social, economic, and environmental factors on health and well-being. O'Rourke and Macrina (1989) make the distinction between micro (individually oriented approaches) and macro (a shared community orientation) approaches to health promotion and highlight the need to redirect our emphasis on the micro approach to health promotion to a combined micro-macro approach. The current "war on drugs" and "just say no" campaigns provide key examples of how the victim-blaming philosophy is reflected in government programs. The heavy emphasis on individual responsibility for drug-taking behavior results in an overemphasis on enforcement of drug laws and other punitive measures. It justifies our acceptance of such punitive measures and negates the need to provide equal access to employment and education for many people engaged in drug use behaviors.

Placing responsibility for health squarely on the shoulders of the individual provides society with quick and easy answers to complex problems. Clearly, this response is easy to sell to the uninformed but not likely to ameliorate effectively many health problems.

Inherent in the blame the victim approach is the fact that we tend to place values on certain health behaviors and risks (McLeroy et al.,1987). Smoking, lack of exercise, and low-fiber diets are perceived as greater risks than restricted economic or social conditions or lack of access to education. The link between income and educational levels and health status have been clearly established. The focus on individual responsibility absolves the government and society of the need to address economic, educational, and societal causes of these problems.

O'Donnell (1988) believes that health professionals need to commit to changing the economic and social inequities that discourage healthy lifestyle behaviors. The following case study highlights this notion. A local corporation employing a large clerical staff was concerned about rising health care costs which they perceived to be a function of a sedentary, overweight workforce. The company decided to give employees a health risk assessment and encouraged them to enroll in some company-supported aerobics programs at a local fitness center.

Employee response was marginal. Upon further study, it was determined that other factors such as lack of child care, low levels of social support within the fitness facilities, and limited economic resources adversely affected participation. Raising the income levels of the employees may be a more effective way to improve diet and provide the fiscal resources to purchase day care and to enroll in fitness classes. The employer could have arranged for child care at the fitness facility as part of its support for the program.

The relationship between lifestyle and health has influenced how we view health promotion and disease prevention. It is understood that al-though individual behaviors influence health status, the responsibility to improve the health of the individual should be a shared responsibility.

THE LIMITATIONS OF PREVENTION

Minkler (1989) indicates that the Health Objectives of the Nation (U. S. Surgeon General, 1980) serve to focus attention on health promotion and disease prevention by emphasizing the need for policy, legislative, and institutional change as well as individual change. McGinnis (1985) states, "For the first time a comprehensive national agenda for prevention has been developed with specific goals and objectives for anticipated gains" (p. 255).

Although the Surgeon General's objectives provide a blend of the micro and macro approaches to health promotion, there are some clear limitations to the maximum expectations for successfully attaining these objectives. McGinnis (1985) outlines these parameters for the biological, technological, ethical, and economic limitations of health promotion.

The biological limitations are based on the extent to which the human lifespan is subject to alteration. A widespread misconception is that the human lifespan is not increasing. The age at which the average individual would die if there were no disease or accident is about 85 years and has been constant for centuries. Although the maximum life potential, or age of the longest lived person is about 115 years, not everyone can expect to live that long, even under optimal conditions (Fries & Crapo, 1981).

On the other hand, life expectancy, or the expected age of death for the average individual, has been rising during the past 100 years. Examination of population sequential survival curves in the United States during the past century depicts these changes. A key benefit of health promotion is the reduction of health risks, which in turn will increase life expectancy without purporting to increase the human lifespan. Using this premise, ideal longevity for an individual is when life expectancy reaches or nearly reaches maximum potential lifespan. If most major health risk behaviors can be controlled, as a society we can begin to approach the ideal lifespan (with the exception of trauma-related deaths). It should be noted that increasing life expectancy relates to the elimination of premature death rather than the extension of the natural lifespan and that lifestyle health behaviors have the greatest potential to improve fife expectancy.

Initially, economic and social progress diminished the effects of infectious diseases, poverty, malnutrition, and famine and significantly changed life expectancy. For example, in 1840, death occurred at nearly a constant rate throughout the natural lifespan. By 1900, although infant mortality was still a significant factor, the growth curve was beginning to change, and life expectancy was increasing.

The changing shape of the growth curve from 1900 to the present resulted from environmental, societal, and individual changes to improve health such as refrigeration, food processing, transportation improvements, and better personal hygiene.

Another important effect of health enhancement programming is the postponement of chronic disease. A compression of the period of infirmity is likely to result from enhanced health across the lifespan. This compression of infirmity will occur with the postponement of chronic disease. Health enhancement programs that are successful in reducing risky behaviors are likely to have an impact on compressing infirmity until later in the life course (Fries & Crapo, 1981).

If the maximum potential lifespan is fixed, the results of improved health mandates that the period of illness becomes shorter and illnesses become less lingering. Also, in some cases, certain chronic disease will not occur at all and the period of adult vigor will be prolonged. These premises support the need to examine quality of life over quantity of life without negating the progress already made by medical sciences. In addition, the Fries and Crapo (1981) model highlights the prolongation of vitality in the adult years and a decreased period of diminished capacity. Under this model, successful health promotion programs should enhance the quality of life without ignoring the basic biological limits inherent in the human lifespan.

To conclude, if the human lifespan appears fixed, our main goal in health promotion should be to improve the quality and vitality of life by examining these lifestyle factors which may have the greatest influence in postponing the onset of infirmity. Contrary to the medical model, these activities are geared less toward intervention after the onset of disease and more to-ward prevention, although total prevention is often not possible.

Technological limitations are difficult to predict. Yet, there are limitations to the prevention of disease. McGinnis (1985) states, 'We often speak glowingly of the end of infectious diseases as a threat to health, but

the fact is that serious problems still exist" (p. 256). For example, although Malaria is virtually non-existent in the United States because the technology exists to control this infectious disease, it remains a problem on a worldwide basis. Of the 150 million cases of Malaria reported annually in Africa, one million result in death. Clearly, the technology exists to control this disease, but the means to implement it worldwide is limited. Technological limitations become even more acute regarding AIDS. Preventive technology is much more difficult to implement in areas in which educational levels are minimal and social customs influence behaviors. Some ethical limitations of prevention have been highlighted in the section on victim blaming. The emphasis on changing lifestyles has some inherent ethical limitations.

- Should we blame the overweight person for a heart attack?
- Should we make smokers pay higher health insurance premiums?
- Should we blame the Type A personality for a stroke?

Formal restrictive actions (e.g., safety belt laws, no smoking policies, mandatory drug testing, etc.) should be carefully examined.

Ethical implications arise when we determine for others which behaviors and conditions are acceptable or unacceptable. Clearly, we need to strike a balance between the pursuit of health and the right of the individual to act in a free and autonomous manner.

Economic limitations of prevention are rooted in the well-established health care delivery system. This system supports, almost exclusively, the treatment of conditions and health problems after onset. McGinnis (1985) states that about 4% of the federal expenditures for health are earmarked for prevention and that "the expenditures are small compared to the potential gains in many areas" (pp. 258-259). Historically, fiscal reserves have not been allocated for prevention activities at the same levels as treatment.

COST BENEFIT ISSUES

The complex and interrelated nature of health problems, limit the degree to which we can show the cost effectiveness of a health promotion intervention. It is logical that improved health may yield a reduction in the use of the health care delivery system and, consequently, reduce health care costs. Therefore, the real promise of health promotion intervention is the reduction of risk which will lead to a reduction in expenditures for health (medical) care. Eddy, Gold, and Zimmerli (1989) state that

> although this linkage seems tautological, given the constraint often inherent in evaluating the impact of employee health promotion programs, it is easy to provide suggestive evidence of the cost effectiveness of health promotion but more difficult to provide clear linkages between programs and cost containment. (p. 8)

The limitations of the economic argument for prevention is clearly outlined in Warner's discussion of the uses and abuses of the economic argument in selling health promotion programs to corporate America (Warner, 1987; Warner, Wickizer, Wolfe, Schildroth, & Samuelson,1988). Warner believes that although interest in worksite health promotion is driven by both profit and altruistic concerns, health promotion providers and the corporations have been too eager to accept the potential economic benefits of worksite health promotion as gospel:

> Both the business and wellness communities have embraced the notion that business can contain its cost and simultaneously improve the health of its workers by engaging in a wide variety of health promotion programs. (Warner et al., 1988, p. 106)

Yet, these cost benefit projects are based on primarily anecdotal evidence and flawed research designs (Warner et al., 1988).

Health promotion programs are now being perceived as but one on a menu of possible strategies to control health care costs. Health promotion programs are expected to reduce health care costs by improving the health or changing the health behavior of the individual. Beyond the difficulty in changing and sustaining a change in a health behavior, there are numerous flaws in the argument to use health promotion programs as a means to control health care cost (Warner, 1987). Some of these include:

- Health promotion programmers do not consider pension or prolonged treatment costs. Cost-benefit analysis of smoking cessation interventions often do not consider the increased cost of medical benefits and increased use of pension benefits by participants who do not die prematurely.

- When developing cost-effective projections, the most optimistic projections of long-range outcomes are used. Often, these projections are not supported in the literature.

- Behavior change is equated with the elimination or significant reduction of risk. Projections need to provide a realistic assessment of risk reduction. For example, increasing fiber intake does not eliminate risk for colon-rectal cancer and increased safety belt use does not eliminate death and disability due to motor vehicle accidents.

- The impact of endogenous changes are often not considered. An endogenous change occurs in society independent of the health promotion program. Decreased smoking behavior and increased exercise behaviors among adults are examples. These changes will occur regardless of our health promotion initiatives.

- Failure to consider other opportunity costs. Corporations examining cost effectiveness must examine the potential benefits of investing the monies spent on health promotion elsewhere in the corporation.

Warner (1987) believes that because of these limitations and flaws in the economic arguments for health promotion that health promotion programs do not provide viable alternatives to other forms of health care cost containment such as a redesign of health insurance coverage or alternative health delivery systems.

The economic limitations to prevention need to be more carefully addressed in the literature. Suffice to say that it is important that health promotion professionals not be caught in the trap of justifying and defending prevention programs on the grounds that they will yield cost-benefit results.

EMERGING TRENDS

The discussion to this point has highlighted some historical perspectives and some flaws in the health promotion movement. Yet, several emerging trends will likely shape health promotion in the future. Two such trends are

- the development of more comprehensive models for health promotion intervention, and

- the reemergence of schools as health promotion programming sites.

The potential victim-blaming nature of early health promotion programs has led to the development of intervention models which focus on social, environmental, and economic factors influencing health behavior, in addition to lifestyle factors. This approach is best typified by the efforts of McLeroy, Bibeau, Steckler, and

Glanz (1988) to develop an ecological perspective on health promotion programs. This conceptual framework purports that health behavior is determined by a variety of factors such as

- intrapersonal factors (knowledge, attitudes, skills, self-concept, history, etc., of the individual)
- interpersonal processes and primary groups (the impact of family, friends, co-workers, and other social support groups on health behaviors and decisions)
- institutional factors (formal and informal rules and regulations of an organization that may impact on a health behavior such as smoking policies or community attitudes that encourage abusive drinking)
- community factors, such as the relationship between institutional (e.g., public health agencies, schools, voluntary health organizations, etc.) and informal networks (e.g., churches, clubs, etc.), in a defined geographic area
- public policy, such as local, state, and national laws and policies, that impact health behaviors. Examples include smoking restrictions, safety belt laws, and other similar ordinances.

Clearly, this approach to health promotion programming moves away from placing responsibility for health on the individual to a more shared responsibility. It does not negate the role of the individual but highlights the interrelatedness of factors that influence health behavior.

Another such emerging trend is the use of well-planned school health programs as a tool for health promotion. Schools, which can potentially reach 95% of adolescents (Haffner, 1987) may be the best place to provide educational initiatives targeted to this age group. The compulsory nature of school attendance also results in access to a wide cross-section of the U.S. population of adolescents and children.

Comprehensive K - 12 health education/promotion programs, taught by qualified personnel have several inherent advantages. Access to youth across time allows a comprehensive program to provide fundamentals for decision making and self-direction of health behavior. The school setting offers an ideal opportunity for educators and health professionals to work together to empower children with health-promoting skills and to provide them with needed medical services (Iverson,1981).

Comprehensive health education/promotion in the schools can function not only as a change agent but also as a tool to enhance maintenance of behavior change. "Health promotion initiatives in school settings can serve to directly protect, maintain, and promote the well-being of individuals not only during their years as students, but also into adulthood" (Allensworth & Wolford,1988, p. 9).

A clear advantage of school-based health education/promotion programs is the access schools provide to local community resources. Havelock 0971) refers to a system of collaboration of school and community resources as "linkage." Local health departments, hospitals, and other institutions may be able to provide support for school health programs. Kolbe and Iverson (1981) describe the use of a "resource system" and "a repertoire of materials, strategies, and consultants" (p. 68). Monahan and Scheirer (1988) examine the role of state health department dental offices as linking agents in a fluoride mouth rinse program in public schools. The results of their study indicate that using linking agents in the design of the program enhanced diffusion.

School-community coalitions can also assist in providing environmental support to enhance the continuation of behavior change and/or lifestyle maintenance. Student and parental knowledge of the availability of health services (e.g., flu shots, contraceptives etc., from local health departments) and how to access such services, can contribute greatly to maintenance of positive health behaviors. The health and behavioral problems facing today's youth (e.g., drugs, teen pregnancy, AIDS) are complex and require complex interventions. School-

community coalitions provide support for maintenance of healthy behavior and may be of assistance in overcoming the notion of individual responsibility as the only variable affecting one's personal health. Schools could emerge as a prime site for health promotion programs because the environment is right for implementation of programs that include the component of the ecological approach to health promotion programs.

CONCLUDING REMARKS

The nature of the health promotion movement mandates change. It is easy to delineate why the health promotion movement has evolved to its present status but more difficult to predict where it may lead us or what factors will influence future directions. Suffice to say that there is a clear need to examine carefully all aspects of health promotion/wellness in a systematic manner to lay a foundation for future initiatives.

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